Policy/Clarification Number: E2003-053

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CRITERIA FOR PRIOR AUTHORIZATION

Lymphocyte Activation Modifier

PROVIDER GROUP: Pharmacy
Professional

MANUAL GUIDELINES: The following drug(s) require prior authorization:
Alefacept (Amevive®)

CRITERIA for alefacept: (must meet all of the following)

1. The patient has not taken another biologic agent (see attached table) in the past 30 days.
2. The patient does not have a diagnosis of HIV or AIDS.
3. The patient is 18 years of age or older.
4. The patient has a diagnosis of plaque psoriasis.
5. The prescriber is a rheumatologist or dermatologist.
6. The patient has taken oral agents for the treatment of plaque psoriasis (see attached table) **or** the patient is a candidate for systemic therapy or phototherapy.
7. The patient's most recent CD4 count is > 250 cells/ul.

Prior Authorization may be approved for six (6) months.

Biologic Agents

Generic Name	Brand Name
Abatacept	Orencia®
Adalimumab	Humira®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Ustekinumab	Stelara®

Oral Plaque Psoriasis Therapy

Generic Name	Brand Name
Acitretin	Soriatane®
Cyclosporine	Sandimmune®
Methotrexate	Trexall®, Rheumatrex®